[redacted]

☐ **ATTACHMENT INDICATOR**
REQUEST FOR PRIOR AUTHORIZATION

FORM NUMBER
24 06 37

UTAH DEPARTMENT OF HEALTH
MEDICAL SERVICES FORM

STATE USE ONLY	
6. Effective Date	
7. Termination Date	

1. Patient Name: Last, First, M.I.	2. Age	3. Sex	4. Client I.D. Number
5. Patient Street Address, City, State, Zip Code			

8. Proposed Medical Supplies, Drug, Therapy, or Surgical Procedures (Identify Primary Procedure First)	9. PROCEDURE/NDC OR SURGICAL CODE	10.Units	11. Estimated Cost	12. STATE USE ONLY		
				Approved Amount	Units	Yes/ No
1						
2						
3						
4						
5						

13. Will the services of an: A. Anesthesiologist be used? | | Yes
B. Assistant at surgery be used? | | Yes

14. Can this procedure be done in your office? | | Yes | | No (if no, complete items 15 through 18 below.)

15. Hospital or Surgical Center Name and Address	16. STATE USE ONLY Faculty Provider Number	17.Estimated hospital days of stay	18. ICD-9-CM CODE	19. STATE USE ONLY Approved Length of Stay	Approved

20. SUMMARY OF HISTORY: (Physical Examination, Laboratory, X-ray studies, prescriptions, and other applicable documentation must be supplied in sufficient detail to justify the necessity for the procedure. If the patient is mentally retarded or under psychiatric treatment, please so indicate and attach additional documentation as appropriate,)

21. Non-Therapeutic Sterilization Request, complete "A" through "C" below. Also attach the completed copy No. 1 of Form 499-A (Part II), before mailing to this office.

*A. Is the above patient in an institution or a correctional facility? | | Yes | | No

*B. Is the above patient mentally ill? | | Yes | | No

*C. Is the above patient mentally retarded? | | Yes | | No

Patient's Date of Birth _____
MM DD YY

22. Name and Address of Requesting or Supplying Provider

DATE OF REQUEST_____
MM DD YY

SIgnature

24. Requesting Provider Number (12 DIGITS)

25. Name and Address of Referring or Prescribing Provider

26. Referring or prescribing Provider License Number

NOTE: This is NOT a certificate of eligibility nor a guarantee of payment amount requested. Eligibility must be confirmed by reviewing an eligibility card current for the month services are to be performed.

FOR STATE USE ONLY

27. Reviewer I.D.

M M D D Y Y

_____
28. Signature of Reviewing Authority

Approval Date

SDH DHCF PA-3 (8/92)

Instructions for Request for Prior Authorization Form

Use this form when requesting Prior Authorization which is required in writing. For more information about Prior Authorizations, refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 9, Prior Authorization Process. To obtain a supply of the Request Form, use the Publications Request Form or call Medicaid Information. (Telephone numbers are in box at bottom of page.) Complete items in **bold print** below. However, items which do not apply may be left blank.

☐ **Attachment indicator** Check if additional information is attached.

1. **Patient Name** Enter the name of Medicaid recipient for whom Prior Authorization Request is being made.
2. **Age** Enter recipient's current age.
3. **Sex** Enter "M" or "F" to indicate gender of recipient.
4. **Client ID Number** Enter the entire 10 digit Medicaid Identification Number of recipient. If this number has not been assigned, enter the patient's Social Security Number. If unknown, enter date of birth.
5. **Patient Street Address** Enter the recipient's address of residence.
6. FOR STATE USE ONLY
7. FOR STATE USE ONLY
8. **Proposed Medical Supplies, etc**. Enter a narrative description of the proposed supply, drug, therapy or procedure. Up to five entries may be made.
9. **Procedure/NDC or Surgical Code** Enter the appropriate number procedure, NDC or surgical code number for procedure requested. NOTE: If you are sending the Prior Authorization form by FAX, please write the codes to the left of item 9, at the end of lines 1 - 5. The original form has the area below item 9 'grayed out'. When the form is sent by FAX, codes written in the colored area are not be readable.
10. **Units** Enter the number of times the procedure requested is to be performed or the total units to be administered.
11. **Estimated Cost** Enter estimated cost for supply/drug/therapy/procedure requested.
12. FOR STATE USE ONLY
13. Will Services of an Anesthesiologist or Assistant Surgeon be used?: Leave blank if information is included in item 20.
14. Can this procedure be done in your office?: Leave blank if information is included in item 20.
15. **Hospital /Surgical Center Name & Address:** Include street address, city, state and zip code.
16. FOR STATE USE ONLY
17. **Estimated hospital days of stay** Enter the estimated number of hospital days of stay.
18. **ICD-9-CM Code** Enter the appropriate ICD-9 code for procedure requested.
19. FOR STATE USE ONLY
20. **SUMMARY OF HISTORY** Enter a narrative description of the patient's history, including documentation to justify the proposed supply, drug, therapy or procedure requested. *Please enter the name and telephone number for contact person in case Medicaid staff have a question about the information.* Attachments may be submitted. **If so, mark the attachment indicator at the top of the form.**
21. **Non-Therapeutic Sterilization Request:** FOR REPRODUCTIVE STERILIZATIONS ONLY. Attach Medicaid Sterilization Consent Form (Form 499-A). Items A, B, and C may be left blank.
22. **Name/Address of Requesting/Supplying provider:** Enter street address, city, state and zip code. Please add phone number.
23. **Date of Request and Signature** Enter date and requesting provider's signature.
24. **Requesting Provider Number** Enter 12 digit Medicaid Provider Number of requesting provider.
25. **Name/Address of Referring/Prescribing Provider:** Enter if different from requesting provider. Include street address, city, state and zip code.
26. **Referring/Prescribing Provider License Number:** Enter the 5 digit Provider License Number of referring provider.

27 - 28. FOR STATE USE ONLY

Mail the original completed form and any attachment to:

MEDICAID PRIOR AUTHORIZATION
BOX 143103
SALT LAKE CITY UT 84114-3103

Requests may be faxed to: 1-801-538-6382
attention 'Prior Authorization.'

QUESTIONS? Call Medicaid Information:

In the Salt Lake City area, call . . . . . 538-6155.
Call toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado: 1-800-662-9651
From all other areas: 1-801-538-6155